Employer: SLAVIN & SLAVIN

Group Number: 600662

CERTIFICATE OF INSURANCE

Humana Insurance Company

This Certificate is not an insurance policy. It is an outline of the insurance provided by the group policy and it does not extend or change the coverage afforded by such group policy. The insurance described by this Certificate is subject to all the provisions, terms, exclusions and conditions of the group policy.

This Certificate supersedes and replaces any Certificate previously issued under the provisions of the group policy.

IMPORTANT NOTICE

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan as paid its portion of the bill. Participating providers have agreed to accept discounted payments for service with no additional billing to the member other than coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll fee telephone number on your identification card.

TERMINATION OF COVERAGE

Termination of Coverage may be immediate or at the end of the period which was selected by **Your Employer** on the Employer Group Application.

Insurance terminates on the earliest of the following:

1. The date this Group Policy terminates;
2. The end of the period for which required premium was due **Us** and not received by **Us**;
3. The date the **Employer's** participation under this Policy terminates;
4. For the **Employee**, the date he or she terminates employment with the **Employer**;
5. For an **Employee**, the date he or she no longer qualifies as an **Employee**;
6. The date **You** fail to be in an eligible class of persons as provided in the Insurance Classifications as stated in the Employer Group Application;
7. The date **You** enter full-time military, naval or air service;
8. The date the **Employee** retires, except if the Employer Group Application provides coverage for a retiree class of **Employees** and the retiree is in an eligible class of retirees, selected by the **Employer**, and **We** are notified by the **Employer**;
9. The date the **Employee** requests termination of insurance to be effective for the **Employee** or **Dependents**;
10. For a **Dependent**, the date the **Employee's** insurance terminates;
11. For a **Dependent**, the date he or she no longer qualifies as a **Dependent**; or
12. For any benefit, the date the benefit is deleted from this Policy.

YOU AND THE **EMPLOYER** ARE RESPONSIBLE TO ADVISE **US** OF ANY CHANGES IN ELIGIBILITY INCLUDING THE LACK OF ELIGIBILITY OF ANY **COVERED PERSON**. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY REGARDLESS OF THE LACK OF NOTICE TO **US**.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

If the **Employer** continues to pay required premiums and continues participation under this Policy, **Your** coverage, other than Short Term Disability benefits, if any, will remain in force for:

1. No longer than three consecutive months if the **Employee** is:
   A. Temporarily laid-off;
   B. In part-time status; or

C. On an **Employer** approved leave of absence.

2. No longer than 12 consecutive months if the **Employee** is **Totally Disabled**.

If the **Employee** becomes **Totally Disabled** and wishes to apply for Waiver of Premium, **We** must receive premium for **Employee** Term Life Coverage for the six consecutive month period while the **Employee** is covered under the Special Provisions for Not Being in Active Status. All premium must be submitted to **Us** through the **Employer**.

If this coverage terminates, the **Employee** may exercise the rights under any applicable Continuation of Medical Benefits provision, or the Medical or Life Conversion Privilege described in this Certificate. If the **Employee** utilizes the Conversion Privilege, he or she thereby waives the right to continue coverage. If the **Employee** returns to an **Active Status**, he or she will be considered a new **Employee** and must re-enroll for **Employee** Coverage.

CONTINUATION FOR LOSS OF EMPLOYMENT

If **Your** medical coverage under the Policy terminates due to loss of employment **You** may continue medical coverage for **You** and **Your** covered **Dependents** if:

1. **You** were covered under the Policy for at least three consecutive months immediately prior to termination;

2. **You** are not eligible for Medicare or other group coverage; and

You and **Your Dependents** are NOT eligible for continuation of medical coverage if **You** were discharged from **Your** employment due to commission of a felony or a theft in connection with **Your** work and for which the **Employer** was in no way responsible; provided that **You** have admitted to commission of the felony or theft or have been convicted or received an order of supervision by a court of competent jurisdiction for such act.

ENROLLMENT

The **Employer** will notify **You** in writing of **Your** right to continue coverage. If **You** elect to continue coverage **You** must notify the **Employer** in writing within ten days following:

1. The date **Your** coverage would otherwise terminate; or

2. The date **You** received written notification of **Your** right to continue coverage.

In no event will **You** be eligible to elect continuation of coverage more than 60 days after the date **Your** coverage would otherwise terminate.

If **You** elect to continue coverage **You** must pay the total monthly premium in advance to the **Employer**. The premium for continuing **Your** coverage will be the rate which would have been applicable to the **Employer** for **Your** group coverage during the continuation period.